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COMMENTS

A DRUG ADDICT'S RIGHT TO ANONYMITY

I. INTRODUCTION

The enormity of the drug abuse problem and its effects upon addict-victims and society are well known. It has been estimated that there are more than 600,000 drug addicts in this country.¹ Initially, the drug problem was considered the concern of law enforcement, a belief still embraced by many.² Society "attacked addiction with police and prisons, rather than with doctors and medical treatment,"³ beginning with the passage of the Harrison Narcotic Act of 1914,⁴ a tax law. Many others, however, including some medical experts, public service attorneys, and lawmakers, believe that because drug addiction is a disease, it is more appropriate to attack the drug problem through medical methods.⁵

The medical approach has been implemented through treatment at specialized clinics or special hospital wards. Treatment methods include

1. Cimino, Doud, Andima & West, *Narcotic Addiction in the United States: A Nationwide Survey*, 2 CONTEMP. DRUG 401 (1973); Hess, van der Voort, Rickey & Rose, *Nature and Trends of Drug Use and Abuse*, 10 CRIM. L. BULL. 637, 637-43 (1974); McNamara & Starr, *Confidentiality of Narcotic Addict Treatment Records: A Legal and Statistical Analysis*, 73 COLUM. L. REV. 1578, 1580-81 (1973).

It is impossible to accumulate accurate statistics on the extent of drug abuse, because drug traffic is an underground activity. Nevertheless, heroin use in this country is thought to be of epidemic proportions. Philadelphia Inquirer, Mar. 23, 1975, at 1, col. 1.

2. *E.g.*, McNamara & Starr, *supra* note 1, at 1581-83.

3. *Id.* at 1581.

4. Act of Dec. 17, 1914, ch. 1, §§ 1-12, 38 Stat. 785, *repealed*, Act of Oct. 27, 1970, PUB. L. No. 91-513, § 1101(b) (3) (A), 84 Stat. 1292. This act taxed narcotics and regulated their importation, sale, and use. It also provided that one convicted for violation of or failure to comply with the act should "be fined not more than \$2,000 or be imprisoned not more than five years, or both, in the discretion of the court." Act of Dec. 17, 1914, ch. 1, § 9, 38 Stat. 789. The Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801 *et seq.* (1970), *as amended*, (Supp. III, 1973) now regulates the importation, sale, and use of narcotics.

5. McNamara & Starr, *supra* note 1, at 1583. In *Robinson v. California*, 370 U.S. 660 (1962), the Supreme Court of the United States held that a California statute which made the status of narcotic addiction itself a criminal offense punishable by imprisonment, inflicted a cruel and unusual punishment, because it was unconstitutional to punish one for having the disease of drug addiction. *Id.* at 667.

"cold turkey,"⁶ methadone detoxification,⁷ and methadone maintenance.⁸ Although enrollment in a treatment program as an alternative to incarceration can be voluntary or compulsory, the success of each program requires the patient's effort and cooperation. As a result, program directors must be able to assure prospective and current patients that their anonymity and the confidentiality of their program records will be protected against disclosure to law enforcement officers, potential employers, or any other individual or group unless the patient consents to their release.⁹ That such assurances are crucial to the operation of the programs was recognized by the Special Action Office for Drug Abuse Prevention (SAODAP)¹⁰ when it stated:

There is clear agreement among drug abuse treatment program operators that their ability to assure patients and prospective patients of anonymity is essential to the success of their programs.¹¹

In light of the importance of these considerations, this Comment will analyze the issue of confidentiality as it relates to the drug addict in a treatment program. Specifically, this Comment will identify the threats to confidentiality and discuss the possible alternatives for protecting it. For this purpose, the discussion has been divided into three parts: threats to confidentiality, with an emphasis upon representative state reporting statutes and a description of the Client Oriented Data Acquisition Process

6. In a "cold turkey" program, an addict is denied all access to the narcotic and consequently must endure the severe physical and psychological pains of withdrawal. For a discussion of withdrawal symptoms, see Wenk, *Methadone Detoxification in Prison: A Case Study of Philadelphia*, in *DISCRIMINATION AND THE ADDICT* 211-14 (L. Simmons & M. Gold eds. 1973).

7. In a methadone detoxification program, a heroin addict is given methadone in increasingly smaller doses in order to eliminate his dependency upon all drugs after a certain period of time.

8. In a methadone maintenance program, the heroin addict is supplied indefinitely with methadone at sufficient doses to prevent withdrawal although he does become addicted to methadone.

9. Disclosure of an addict's identity could have a detrimental effect upon his employment opportunities, which are not numerous in any event. If employers knew or could determine that an individual was an addict, it is unlikely that he would be hired or retained as an employee. See generally Feingold, *Employment Problems of the Ex-Addict: A Case Study of New York*, in *DISCRIMINATION AND THE ADDICT*, *supra* note 6, at 81.

10. SAODAP was created by executive order to utilize the resources of the federal government to combat drug abuse. Exec. Order No. 11,599, 3 C.F.R. 301 (1971), 21 U.S.C. § 801 (Supp. III, 1973). Congress formalized SAODAP in 1972. Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, §§ 201-14, 86 Stat. 67-70 (codified at 21 U.S.C. §§ 1111-23 (Supp. III, 1973)).

11. 37 Fed. Reg. 24636 (1972). See Stern, *Confidentiality: Treatment and Disclosure*, in *DISCRIMINATION AND THE ADDICT*, *supra* note 6, at 193. Both research and treatment would be impeded without confidentiality. Research would be impaired by the reluctance of addicts to supply information necessary to the experiment or survey. Treatment would be affected because addicts would fear that enrollment in treatment programs would lead to police harassment and legal action against them. McNamara

(CODAP);¹² federal laws and regulations intended to insure confidentiality, including an analysis of proposed federal regulations; and legal bases upon which to premise an addict's right to confidentiality.

II. THREATS TO CONFIDENTIALITY

There are three basic threats to addict confidentiality: overzealous law enforcement; state reporting statutes; and centralized recordkeeping processes.¹³ The pervasiveness of police harassment of drug addicts and physicians who treat them, and official intrusions into treatment centers have made some doctors reluctant to treat drug addicts.¹⁴ The existence of such "overzealous enforcement" and its inhibitory effect is well documented.¹⁵ Further discussion of this threat to addict confidentiality, therefore, is outside the scope of this Comment.

A. State Reporting Statutes

In contrast to the comprehensive documentation of the threat posed by law enforcement officials, there has been little analysis of state reporting statutes. Such statutes generally require physicians to file reports with designated health or law enforcement agencies after they treat or examine addicts.¹⁶ This Comment will examine four reporting statutes in particular, those of California, Massachusetts, New York, and Pennsylvania.¹⁷

12. CODAP, a centralized national computer recordkeeping system, is discussed at notes 54-75 and accompanying text *infra*.

13. McNamara & Starr, *supra* note 1, at 1587-96, discussed these threats and presented a statistical analysis of them. Questionnaires were mailed to 974 drug centers located throughout the country. One hundred seventy-two centers representing all parts of the country and utilizing the full range of treatment methods responded. The statistical survey was based upon these responses. *Id.* at 1579 n.1.

14. *See id.* at 1587-90, where the authors list statistics and individual instances where law enforcement has interfered with the medical approach to the drug problem.

15. *Id.* at 1587-90.

16. According to McNamara and Starr, 15 states have enacted reporting statutes. *Id.* at 1590 n.49. It should be noted that Pennsylvania has since repealed that reporting statute. The Controlled Substance, Drug, Device and Cosmetic Act, § 43, PA. STAT. ANN. tit. 35, § 780-143 (Supp. 1974), *repealing* the Drug, Device and Cosmetic Act, § 8 [1961] P.L. 1664.

17. The California statute was selected because California has been considered a center of drug traffic. The New York statute was chosen, not only for the same reason, but also because *People v. Newman*, 32 N.Y.2d 397, 298 N.E.2d 651, 345 N.Y.S.2d 502 (1973), *cert. denied*, 414 U.S. 1163 (1974), a significant case for the issues discussed in this Comment, arose in this jurisdiction. For a discussion of this case, *see* notes 100-11 and accompanying text *infra*. Finally, the Massachusetts and Pennsylvania statutes were picked primarily for their attempts to ensure confidentiality and because these states rejected the original proposal for the Centralized Record System, the Client Oriented Data Acquisition Process. *See* notes 66-75 and accompanying text *infra*.

1. *California*

The California Uniform Controlled Substances Act¹⁸ requires every physician who prescribes, furnishes, or administers a narcotic drug in the treatment of an addict for addiction to report to the Attorney General of California the name and address of the patient and the name and quantities of the narcotic substance used.¹⁹ Unfortunately, the California law does not provide for the confidentiality of these reports and in no way protects addict anonymity.

As a result, physicians and addicts, in *Blinder v. State*,²⁰ challenged the constitutionality of the statute upon several grounds.²¹ The primary

18. CAL. HEALTH & SAFETY CODE §§ 11000 *et seq.* (West Supp. 1974). The Uniform Controlled Substances Act has been enacted in 43 jurisdictions, including Massachusetts, MASS. GEN. LAWS ANN. ch. 94C, §§ 1-48 (1972); New York, N.Y. PUB. HEALTH LAW §§ 3300-96 (McKinney Supp. 1974); and Pennsylvania, PA. STAT. ANN. tit. 35, §§ 780-101 to -144 (1974 Supp.).

19. Section 11221 of the California Uniform Controlled Substances Act (the California Act) provides:

The physician prescribing, furnishing, or administering any narcotic controlled substance in the treatment of an addict for addiction shall within five days after the first treatment report by registered mail, over his signature, to the Attorney General stating the name and address of the patient, and the name and quantities of narcotic controlled substance prescribed.

The report shall state the progress of the patient under treatment.

The physician shall in the same manner further report on the 15th day of the treatment and on the 30th day of the treatment, and thereafter shall make such further reports as is required by the Attorney General.

CAL. HEALTH & SAFETY CODE § 11221 (West Supp. 1974).

Section 11230 of the California Act states:

A physician prescribing or furnishing a controlled substance classified in Schedule II [including methadone] to an habitual user shall within five days after first prescribing or furnishing the controlled substance personally report in writing by registered mail, over his signature, to the Attorney General.

The report shall contain all of the following:

- (a) Name of the patient.
- (b) Address of the patient.
- (c) Character of the injury or ailment.
- (d) Quantity and kind of controlled substance used.
- (e) A statement as to whether or not the patient is an addict.

Id. § 11230.

20. 25 Cal. App. 3d 174, 101 Cal. Rptr. 635 (1972).

21. The plaintiffs attacked the statute as it existed prior to the adoption of the Uniform Controlled Substances Act. Since all of the sections of the prior law were reenacted into the present California Act, the current citations will be noted, with the former citations to the CAL. HEALTH & SAFETY CODE (West 1964) appearing in parentheses.

The physicians and addicts in *Blinder* challenged section 11217 of the California Act (formerly section 11391), which lists the only places in which an addict may be treated for addiction, section 11219 (formerly section 11392), which imposes maximum daily amounts of narcotics that may be dispensed for treatment during the first 15 days of medical attention, section 11219 (formerly section 11393), which imposes maximum daily amounts after the first 15 days of treatment, section 11220 (formerly section 11394), which limits the durations of treatment to 30 days, and section 11221 (formerly section 11395), which is the reporting statute (*see note 19 supra*). 25 Cal. App. 3d at 177, 101 Cal. Rptr. at 637.

The plaintiff physicians argued that sections 11217-20 of the California Act (formerly sections 11391-94) deprived them of the right to practice medicine without

contention was that the statute infringed upon the addict's fifth amendment right against compulsory self-incrimination because it compelled addicts to be witnesses against themselves in that, when seeking treatment for addiction, the addicts were forced to expose themselves to the "real and appreciable risk of being identified as habitual users of narcotics which in turn [could] result in criminal prosecution."²² The court reasoned that the plaintiffs could invoke the privilege against self-incrimination only if they could show that the compelled disclosures would, in themselves, substantially threaten the fifth amendment right.²³ Surveying the case law, the *Blinder* court stated:

The cases in which reporting procedures were found to be invalid because they violated the privilege against self-incrimination are those in which the disclosures condemned were "extracted from a 'highly selective group inherently suspect of criminal activities' and the privilege was applied only in 'an area permeated with criminal statutes' — not 'an essentially noncriminal and regulatory area of inquiry.'"²⁴

Thus, the statute was held valid because it operated in a noncriminal, regulatory area of inquiry and was not directed toward a highly "selective" group suspected of criminal activities.²⁵

The soundness of this conclusion, however, is itself suspect, upon two grounds. First, while it is true that the statute was regulatory in nature,

due process of law. *Id.* at 179, 101 Cal. Rptr. at 638. The court rejected this argument, reasoning that rather than prohibiting physicians from practicing medicine, the law merely limited the practice, and concluded that such a limitation was a reasonable exercise of the police power. *Id.* at 180-81, 101 Cal. Rptr. at 639. Based upon the belief that use of methadone for treatment of addicts was unlawful under section 11374 (formerly section 11716), the physicians also contended that section 11211 (formerly section 11391), by requiring them to report their unlawful use of methadone for treatment compelled them to be witnesses against themselves. In response, the court stated that the use of methadone was not unlawful; and, therefore, the reporting statute did not require the physicians to report criminal activity. *Id.* at 186, 101 Cal. Rptr. at 643.

The plaintiff-addicts argued that sections 11217-20 (formerly sections 11391-94) deprived them of their right to proper medical treatment without due process of law. *Id.* at 179, 101 Cal. Rptr. at 638. The court assumed *arguendo* that a right to medical treatment existed which precluded the state from making unavailable a safe and effective drug that was essential to an individual's health and well-being, but rejected the due process argument upon the basis that the statute, in merely regulating the dispensing of the drug, was a reasonable use of the police power. *Id.* at 182-83, 101 Cal. Rptr. at 640-41. The plaintiff-addicts further argued that the statutes denied them equal protection of the laws in that they limited the use of methadone for treatment of addiction but permitted unlimited use of methadone for treatment of other diseases. *Id.* at 184, 101 Cal. Rptr. at 642. The court dismissed this argument because the plaintiffs had failed to allege facts demonstrating that the statute was palpably arbitrary. *Id.* at 185, 101 Cal. Rptr. at 642. Finally, the addicts alleged that the statutory scheme inflicted cruel and unusual punishment, an argument that the *Blinder* court rejected because the statute, while regulating the dispensing of methadone, did not totally deprive an addict of the substance for treatment. *Id.* at 185-86, 101 Cal. Rptr. at 642-43.

22. 25 Cal. App. 3d at 186, 101 Cal. Rptr. at 643.

23. *Id.*

24. *Id.* at 187, 101 Cal. Rptr. at 644, quoting *California v. Byers*, 402 U.S. 424, 430 (1971), quoting *Albertson v. SCAB*, 382 U.S. 70, 79 (1965).

25. 25 Cal. App. 3d at 187, 101 Cal. Rptr. at 644.

the policy behind requiring disclosure was not merely regulatory. The state may have had a need to know the number of drug addicts within its borders for purposes of allocating resources to combat drug abuse, but requiring disclosure of the actual identity of addicts was not necessary to serve that end.²⁶ Rather, disclosure of addict identity merely provided law enforcement officials with information enabling them to monitor the activities of addicts. Second, contrary to the court's conclusion, drug addicts do indeed constitute a highly selective group inherently suspected of criminal activity. Because addicts frequently resort to crime to support their habits, the addict is often monitored for the purpose of apprehending him in committing a crime. The unfortunate result of the court's finding is more far-reaching than its mere provision of the law with a conceptual error: if addicts know or suspect that enrollment in a treatment program will supply law enforcement officers with a source of information about them, addicts will become suspicious of treatment programs and will be reluctant to seek treatment. Thus, in finding addicts a non-suspect group and the area regulatory rather than criminal, the *Blinder* court declined to fashion a rule that might have encouraged addicts to enroll in treatment programs. The privilege against self-incrimination should have been applied to invalidate the California reporting statute. Nevertheless, as it now stands, in California, the reporting statute requires disclosure of the identity of addicts under treatment without ensuring confidentiality.²⁷

2. *Massachusetts*

The statutory scheme in Massachusetts differs significantly from that in California. The statute applies to both physicians²⁸ and treatment facilities.²⁹ In Massachusetts, although there is no requirement that physicians report the name of addict patients, the statute does require a report of certain identifying information.³⁰

26. The argument can be made that the addict's actual identity is necessary to protect the integrity of statistical surveys, because such knowledge precludes the possibility that a single addict will be counted more than once. Other methods, however, are available to protect the integrity of a statistical analysis, such as a system of unique identifiers which could not be translated into the actual identity of the client by anyone other than the treatment facility.

27. Even the evidentiary physician-patient privilege cannot effectively protect confidentiality in California, because it does not apply in criminal proceedings. CAL. EVID. CODE § 998 (West 1966). See notes 138-43 and accompanying text *infra*.

28. Various provisions of the Massachusetts version of the Uniform Controlled Substance Act, MASS. GEN. LAWS ANN. ch. 94C, §§ 1-48 (1972), as amended, (Supp. 1974), apply to physicians.

29. *Id.* ch. 123, § 44 (Supp. 1974).

30. Section 24(a) of the Massachusetts Uniform Controlled Substance Act (the Massachusetts Act) provides:

A practitioner who dispenses a controlled substance . . . [including methadone] . . . for the purpose of treating for his drug dependency a drug dependent person . . . shall report to the commissioner of mental health or his designee identifying information and the address of each . . . patient to whom such controlled substance is dispensed, and the name, and dosage and strength per dosage unit

However, the statute does attempt to protect the addict's confidentiality by denying law enforcement officials access to such information and by prohibiting its use in a criminal prosecution.³¹

With respect to addicts enrolled in treatment facilities, the Massachusetts statute provides:

Each facility shall file with the division from time to time, on request, such data, statistics, schedules or information as the division may reasonably require for the purposes of this section³²

It should be noted that there is no requirement that specific names of individual clients be disclosed, and, significantly, that another section states:

The administrator of each facility shall keep a record of the treatment afforded each patient, which shall be confidential and shall only be made available upon judicial order, whether in connection with pending judicial proceedings or otherwise³³

Hence, patients of treatment facilities are not afforded as much protection as patients of private practitioners because the information may be disclosed upon court order.³⁴ While the Massachusetts provisions are superior from the addict's point of view to those of California, they fail to provide the degree of protection that would enable a treatment facility to assure the client that facility records would be kept absolutely confidential.

3. *New York*

Similarly, the New York State Controlled Substances Act³⁵ (New York Act) places addict confidentiality in jeopardy. According to the New York Act, by the tenth day of each month, a person certified to conduct a maintenance program must report to the state the name and address of each applicant awaiting admission and each applicant who has been ad-

of the substance so dispensed. Said commissioner shall maintain records of each such report.

Id. ch. 94C, § 24(a) (1972).

31. Section 24(b) of the Massachusetts Act states:

Such records maintained by the commissioner of mental health shall be closed to the public and shall not be available to any law enforcement official for any purpose, nor shall they be used in the criminal prosecution of such research subject or patient pursuant to any provision of this chapter, nor shall they be admissible in evidence against such research subject or patient in any criminal proceeding.

Id. § 24(b).

32. *Id.* ch. 123, § 44 (Supp. 1974).

33. *Id.* § 55(a).

34. The relationship between the two statutes is unclear. If most treatment program operators are physicians, it is arguable that the statute requiring disclosure of the confidential information upon court order is inoperative because it would require the physician to violate the statute which precludes disclosure. However, this issue has not been litigated.

35. N.Y. PUB. HEALTH LAW §§ 3300-96 (McKinney Supp. 1974).

mitted into the program.³⁶ Confidentiality of facility records is mandated by the statute, as it is in Massachusetts, unless the disclosure is compelled by court order.³⁷ However, New York expressly permits use of the treatment program information in a criminal investigation or proceeding.³⁸

The New York scheme also imposes duties upon private practitioners. Like the California law, each attending practitioner must report to the state commissioner the name and address of any person determined to be a narcotic addict,³⁹ with the important distinction that the information must be "kept confidential and may be utilized only for statistical, epidemiological or research purposes . . ."⁴⁰

Thus, the New York scheme is more onerous on the addict than that of Massachusetts, because it requires disclosure of the names of treatment clients. Some protection to the addict is provided, however, for like the Massachusetts provision relating to treatment facilities, confidentiality is required except when disclosure is compelled by court order.

36. *Id.* § 3355. The state, under the statute, was to establish a central registry to assemble the information including the name and other identifying information regarding the addict. That information would be available only to a practitioner attempting to ascertain the status of an addict seeking treatment or admission to a treatment program, or to a government department authorized to gather such information. *Id.* § 3356.

37. *Id.* § 3371(1)(b).

38. *Id.* § 3371(1)(c).

39. *Id.* § 3322(1). This section was challenged in *Roe v. Ingram*, 364 F. Supp. 536 (S.D.N.Y. 1973). In *Ingram*, patients who were given controlled substances listed in Schedule II of the New York Act to relieve pain complained that the statutory requirement that the treating physician report their names to the state violated their rights to privacy and sought a preliminary injunction against enforcement of the law. In deciding that there was no demonstration by the plaintiffs of a probability of success upon the merits sufficient to compel the issuance of a preliminary injunction, the court stated that, at present, the constitutional doctrine of the right to privacy did not extend to this type of case. *Id.* at 546. Moreover, even if the doctrine were extended, the plaintiffs had not demonstrated that the competing state interests were insufficient to overcome their injury. *Id.* at 546. See notes 168-88 and accompanying text *infra* for a discussion of the right to privacy as a legal basis for an addict's right to anonymity.

It should be noted that the reporting required in New York is not effectively limited by the evidentiary physician-patient privilege, because the statute provides:

For the purposes of duties arising out of this article, no communication made to a practitioner shall be deemed confidential within the meaning of the civil practice law and rules relating to confidential communications between such practitioner and patient.

N.Y. PUB. HEALTH LAW § 3373 (McKinney Supp. 1974). See notes 137-67 and accompanying text *infra* for a discussion of the physician-patient privilege as a basis for an addict's right to anonymity.

40. N.Y. PUB. HEALTH LAW § 3372 (McKinney Supp. 1974). The relationship between sections 3371 and 3372 is nowhere made clear. Thus, whether a physician who operates a treatment facility can be compelled by court order to disclose confidential information to be used for other than statistical, epidemiological, or research purposes

4. *Pennsylvania*

Pennsylvania law furnishes an additional method of supervision over the dispensation of controlled substances. There is no actual reporting statute, but section 12 of the Controlled Substance, Drug, Device and Cosmetic Act⁴¹ (Controlled Substance Act) provides that records be maintained concerning what substances were distributed and the names and addresses of the patients involved.⁴² Significantly, the Pennsylvania legislature seemed particularly sensitive to the confidentiality issue in enacting the Controlled Substance Act, because section 37(c) provides:

A practitioner engaged in medical practice or clinical research is not required nor may he be compelled to furnish the name or identity of a patient or research subject to the secretary, nor may he be compelled in any State or local civil, criminal, administrative, legislative or other proceedings to furnish the name or identity of such an individual.⁴³

Another Pennsylvania statute also requires the gathering of information about addicts who may be treated. Unlike the Controlled Substance Act, which seeks to regulate the distribution of certain drugs, the Pennsylvania Drug and Alcohol Abuse Act⁴⁴ (Drug and Alcohol Act) was intended to implement "a comprehensive health, education and rehabilitation program for the prevention and treatment of drug and alcohol abuse and dependence," by establishing a Governor's Council on Drug and Alcohol Abuse (Governor's Council) to coordinate such a program.⁴⁵ Section 8(a) directs that certain data be compiled in order to develop case histories of patients treated in programs developed pursuant to the Drug and Alcohol Act;⁴⁶ section 4 permits the Governor's Council to obtain information and publish statistics pertaining to drug and alcohol abuse.⁴⁷ However, elaborate precautions are provided to insure confidentiality and addict anonymity.⁴⁸

41. PA. STAT. ANN. tit. 35, §§ 780-101 to -144 (Supp. 1974).

42. Section 12 of the Controlled Substance Act provides:

Every practitioner licensed by law to administer, dispense or distribute controlled substances shall keep a record of all such substances administered, dispensed or distributed . . . [and] the name and address of the patient . . .

Id. § 780-112(b).

43. *Id.* § 780-137(c).

44. PA. STAT. ANN. tit. 71, §§ 1690.101-115 (Supp. 1974).

45. *Id.* § 1690.103.

46. *Id.* § 1690.108(a).

47. *Id.* § 1690.104.

48. Section 4(e) of the Drug and Alcohol Act states:

Such statistics shall not reveal the identity of any patient or drug and alcohol dependent person or other confidential information.

Id. § 1690.104(e).

Section 4(a)(8) provides additional protection:

Any information obtained through scientific investigation or research conducted pursuant to this act shall be used in ways so that no name or identifying characteristics of any person shall be divulged without the approval of the council and the consent of the person concerned. Persons engaged in research pursuant to this section shall protect the privacy of individuals who are the subject of such

Pursuant to this statute, the Governor's Council has proposed detailed information regulations.⁴⁹ According to these proposed regulations, no information collected by the state regarding an individual who, as a result of drug abuse or dependence, is or has been the recipient of the services of a treatment program can be disclosed to any person, agency, institution, governmental unit, or law enforcement personnel, subject to nine exceptions designed to obtain for the client benefits due him.⁵⁰ The expressed

such research the names or other identifying characteristics of the individuals. *Id.* § 1690.104(a) (8).

Section 8 contains the restrictions upon the use of patients' records:

(b) All patient records . . . prepared or obtained pursuant to this act, and all information contained therein, shall remain confidential, and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient. Disclosure may be made for purposes unrelated to such treatment or benefits only upon order of a court of common pleas after application showing good cause therefor. In determining whether there is good cause for disclosure, the court shall weigh the need for information sought to be disclosed against the possible harm of disclosure to the person to whom such information pertains, the physician-patient relationship, and to the treatment services, and may condition disclosure of the information upon any appropriate safeguards. No such records or information may be used to initiate or substantiate criminal charges against a patient under any circumstances.

(c) All patient records and all information contained therein relating to drug or alcohol abuse or drug or alcohol dependence prepared or obtained by a private practitioner, hospital, clinic, drug rehabilitation or drug treatment center shall remain confidential and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situation where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient.

Id. § 1690.108(b), (c). Section 8 is almost identical to the confidentiality provisions of the Federal Drug Abuse Office and Treatment Act of 1972, 21 U.S.C. § 1175 (Supp. III, 1973). Hence, the analysis of the federal act (*see* notes 77-119 and accompanying text *infra*), should apply to the Pennsylvania provisions.

49. 4 PA. BULL. §§ 290.1 *et seq.* at 2488-90 (Dec. 7, 1974).

50. *Id.* § 290.4a. The exceptions are that information can be disclosed: 1) to a judge who has imposed sentence upon a particular client when enrollment in a treatment program is a condition of the sentence, 2) to the client's probation or parole officer where treatment is a condition of probation or parole, 3) to judges who have assigned a client to a treatment program under a presentence, conditional release program, 4) by client application to a judge for assistance in deciding whether to initiate conditional release status for the client, with the client's written consent, 5) to the client's attorney in a criminal, civil, or administrative proceeding, 6) to employers or prospective employers who seek to further client rehabilitation or who seek to employ treatment clients, 7) to an insurance company, health or hospital plan which has contracted with the client to provide medical benefits, 8) to governmental officials to obtain for the client government benefits, and 9) to a licensed physician who establishes the need for the information to treat a client whose life is in im-

purpose of the proposed information regulations is "to insure the confidentiality of client-oriented data."⁵¹ To effectuate this purpose, the Governor's Council is prohibited from entering the client's name or other identifying information upon any list or into any data processing system.⁵² If adopted, these proposed regulations, coupled with existing statutory provisions, would do a great deal to protect the anonymity of the addict enrolled in a treatment program in Pennsylvania. Nevertheless, as a genus, reporting and recordkeeping statutes are considered a threat to confidentiality and anonymity.⁵³

B. Centralized Record Systems

Centralized nationalized recordkeeping systems also represent a threat to confidentiality.⁵⁴ The major recordkeeping system relating to drug addicts in this country is the Client Oriented Data Acquisition Process (CODAP), a data processing system developed in late 1971 partly to standardize the reporting requirements of several federal agencies.⁵⁵ CODAP was not established under any federal law or regulation; instead, it was implemented through contracts negotiated between the federal and state governments.⁵⁶ The system was primarily designed to determine the nature and extent of the national problem of drug abuse, so that methods of attacking the problem could be devised.⁵⁷

51. *Id.* § 290.5.

52. *Id.* § 290.6.

53. McNamara & Starr, *supra* note 1, at 1594-96.

54. *Id.* at 1595. See generally A. MILLER, *THE ASSAULT ON PRIVACY: COMPUTERS, DATA BANKS AND DOSSIERS* (1971). See also A. WEST, *PRIVACY AND FREEDOM* (1967).

One commentator lists five ways centralized data banks threaten privacy: the invader can 1) utilize one source which has collected and collated the information, 2) update his data quickly with precision, 3) keep track of a certain individual despite the person's mobility, 4) have access to a whole range of historical information about the individual, and 5) detect and interpret potentially self-revealing private information. Michael, *Speculations on the Relation of the Computer to Individual Freedom and the Right to Privacy*, 33 GEO. WASH. L. REV. 270, 273-74 (1964).

55. PENNSYLVANIA GOVERNOR'S COUNCIL ON DRUG ABUSE, MEMORANDUM ON CODAP (copy on file at the *Villanova Law Review*) [hereinafter cited as CODAP MEMORANDUM]. The six agencies whose reporting requirements were involved were the National Institute of Mental Health, the Office of Economic Opportunity, the Veterans' Administration, the Law Enforcement Assistance Administration, and Housing and Urban Development. *Id.* at 2.

56. For example, on July 9, 1973, the city of Boston received a notice of a grant award for almost \$2 million from the National Institute of Mental Health (NIMH). The grant was subject to three conditions: 1) that the applicant document a demonstrated need for the program to be funded by the federal grant; 2) that the grantee participate in CODAP; 3) that the grantee submit an implementation plan approved by the state drug abuse coordinator, the Special Action Office for Drug Abuse Prevention (SAODAP), and NIMH. Letter from Boston Mayor Kevin H. White to Dr. Bertram Brown, Aug. 7, 1973.

57. Zimmerman, *Patients' Right to Privacy Violated Claim Critics of New U.S. Data Bank*, *The Toronto Journal*, Nov. 1, 1973, at 1, col. 3 (on file at the *Villanova Law Review*).

Based upon the findings of a pilot test,⁵⁸ CODAP was modified and divided into two major components, National Management (NM) and Client Management (CM) in order to meet the two objectives of "development of a standardized Federal reporting procedure on client related data, and establishment of minimum standards of information essential to making treatment decisions for individual drug abusers."⁵⁹ The CM component "establishes standards for the acquisition and use of client related data to support the decision-making needs of those directly involved in providing treatment and rehabilitation services."⁶⁰ It was to become effective upon January 1, 1973;⁶¹ however, it is not known at present whether it was ever instituted.⁶² In any event, the NM component proved to be unacceptable to several of the states.

Under the NM component, quarterly reports of admission and case sample information, census information, and funding information must be made by any drug treatment facilities receiving federal funds. The stated purpose of these reports was to "support the decision-making needs of Federal agencies with respect to performance, planning and follow-up in the area of treatment and rehabilitation."⁶³

NM became effective nationally in April, 1973, and sought to answer, through data collection, the following questions: Is treatment capacity adequate? What types of clients are in treatment? What modalities⁶⁴ reflect favorable discharge rates? How are "involuntary" clients responding? What are the most frequent client disposition patterns in each modality? What are the rates of opiate and nonopiate abuse among different client groups? Is the present drug abuse pattern changing?⁶⁵

One portion of the project posed an enormous threat to addict anonymity — the unique identifier aspect of the information requested from the treatment centers. Each center was obliged to fill out a form for each client admitted to the program, and required to supply the following information: 1) the client identifier number of 10 digits;⁶⁶ 2) the client's birth data; 3) the client's zip code; 4) the client's race; 5) the first two initials of the given and maiden name of the client's mother.⁶⁷ The pro-

58. CODAP was pilot tested in 28 treatment programs in 1971. CODAP MEMORANDUM, *supra* note 55, at 1.

59. *Id.*

60. NATIONAL INSTITUTE OF MENTAL HEALTH, CODAP CLIENT MANAGEMENT HANDBOOK 1-1 (May, 1973) (on file at the *Villanova Law Review*).

61. *Id.*

62. Secrecy has surrounded CODAP. Consequently, information could not be obtained concerning whether CM had ever been implemented.

63. NATIONAL INSTITUTE ON DRUG ABUSE CODAP NATIONAL MANAGEMENT HANDBOOK (October, 1973) (on file at the *Villanova Law Review*).

64. "Modality" is the term used to designate the type of treatment used. For a brief description of the various types of treatments, see notes 6-8 *supra*.

65. Zimmerman, *supra* note 57, at 1, col. 3.

66. *Id.* at 2, col. 2. These numbers are coded in such a way that they could not lead to identification of the client by anyone other than those involved at the treatment center. *Id.*

ponents of CODAP said that this information was necessary to protect the integrity of the statistical survey that could be compiled from the CODAP forms because there was no other way to be certain that treatment program enrollees would be counted only once.⁶⁸

In recognition of the grave danger to confidentiality, several states opposed the rendition of the information required by the unique identifier. The Attorney General of Pennsylvania, in an opinion letter to the Governor's Council, stated that participation in CODAP would violate certain provisions of the Pennsylvania Drug and Alcohol Act, specifically sections 4(a)(8), 4(e), and 8(b).⁶⁹ On the basis of this interpretation, the Governor's Council threatened to refuse to enter the contract for the federal funds.⁷⁰

Pennsylvania was joined in its opposition to the unique identifiers in CODAP by Massachusetts. The Massachusetts Department of Mental Health viewed reporting the requested information as a violation of the duty imposed upon a physician by the physician-patient relationship. In addition, the Department feared that CODAP was an initial step in the subordination of individual privacy and freedom through the use of centralized data systems and computer banks which would ultimately lead to the development of a method of identifying individuals who possessed certain personality or character traits deemed by some to be undesirable. This, in turn could lead to social and political repression.⁷¹

Dr. Matthew Dumont, the Assistant Commissioner for Drug Rehabilitation in Massachusetts Department of Mental Health illustrated the dangers inherent in CODAP's unique identifier.⁷² Assuming that the overwhelming majority of persons in drug treatment programs in Massachusetts were born in that state, he asserted that by the interested agency's going to the State Bureau of Vital Statistics, and mechanically sorting the data cards, individuals enrolled in treatment centers could be identified through the use of CODAP information. The sorting would be performed, seriatim, by year of birth, month of birth, day of birth, sex, and race. The selected cards could then be hand sorted for the first two letters of the mother's maiden and given name. Dr. Dumont contended that on a national level,

68. *Id.*

69. Letter from Israel Packel to Dr. Richard Horman, May 3, 1973 (copy on file at the *Villanova Law Review*). For the text of these sections, see note 48 *supra*. On June 7, 1973, however, the Attorney General, after conferring with SAODAP and being guaranteed that "the Federal Government has no practical means of using the code . . . to discover the identity of its subject from [the] data . . .," informed Dr. Horman that participation in CODAP would not violate state law. Letter from Israel Packel to Dr. Richard Horman, June 7, 1973 (copy on file at the *Villanova Law Review*).

70. Zimmerman, *U.S. Data Collecting System Challenged*, The Toronto Journal, Dec. 1, 1973, at 3, col. 1 (on file at the *Villanova Law Review*).

71. Dumont, C.O.D.A.P.: THE MONSTER MASQUERADING AS A WINDMILL 2-4 (undated and unpublished; copy on file at the *Villanova Law Review*).

72. Dumont, *POSITION PAPER ON CLIENT ORIENTED DATA ACQUISITION PROCESS 1* (undated and unpublished; copy on file at the *Villanova Law Review*).

given the patient's zip code, any individual or agency with access to social security or internal revenue files could follow this sorting procedure and accomplish the same identification with minimal effort and at minimal cost.⁷³

Pennsylvania and Massachusetts remained adamant in their opposition to CODAP and finally were permitted by SAODAP and the National Institute for Mental Health (NIMH) to leave blank the unique identifier portions of the reports. As a result, current CODAP forms no longer request the uniquely identifying information.⁷⁴ Thus, it appears that CODAP itself does not pose the threat to addict anonymity that it once did. Nevertheless, because of the nature of these data compilations, centralized recordkeeping systems do threaten addict anonymity.⁷⁵

III. FEDERAL RULES AND REGULATIONS WHICH PROTECT CONFIDENTIALITY

Two federal statutes, the Comprehensive Drug Abuse Prevention and Control Act of 1970 (1970 Act)⁷⁶ and the Drug Abuse Office and Treatment Act of 1972 (1972 Act),⁷⁷ govern the confidentiality of records relating to drug addicts enrolled in methadone treatment programs. The 1970 Act was designed to regulate the importation, quality, sale, and use of controlled substances. The 1972 Act, however, was enacted to

focus the comprehensive resources of the Federal Government and bring them to bear on drug abuse with the immediate objective of significantly reducing the incidence of drug abuse in the United States within the shortest possible period of time, and to develop a

73. *Id.*

74. NATIONAL INSTITUTE ON DRUG ABUSE, CODAP NATIONAL MANAGEMENT HANDBOOK 3-2, 4-2 (Nov. 1974) (on file at the *Villanova Law Review*).

75. Another centralized drug recordkeeping system that is currently operating is the Drug Abuse Warning Network (DAWN). Project DAWN, established by the Drug Enforcement Administration (DEA) is designed to identify patterns of drug abuse in selected metropolitan areas. DRUG ENFORCEMENT ADMINISTRATION, DAWN HANDBOOK 1 (copy on file at the *Villanova Law Review*). Phase I of the program began in April, 1973, when DEA contracted with a private corporation to obtain drug abuse and drug death statistics. *Id.* at 2. Data was to be gathered from five sources: 1) inpatient units of nonfederal, short-term general hospitals; 2) emergency departments in nonfederal, short-term general hospitals; 3) county medical examiners or coroners; 4) student health centers; and 5) crisis intervention centers not directly affiliated with colleges and universities. *Id.* at 2-3. Data collection was carried out in each participating facility by individuals who completed one form for each drug abuse incident or death occurring during the reporting period. Phase II began in March, 1974, with the objectives of providing data for the assessment of the relative health hazards and abuse potential for substances in current use, and of providing data helpful to SAODAP for planning purposes. *Id.* at 12. The original DAWN forms for hospital inpatient facilities contained blocks for the initials of the maiden name of the patient's mother, but current forms, not contained in the DAWN handbook, do not request information that could uniquely identify the patient.

76. 21 U.S.C. §§ 801 *et seq.* (1970), as amended, (Supp. III, 1973).

77. 21 U.S.C. §§ 101 *et seq.* (Supp. III, 1973).

comprehensive, coordinated long-term Federal strategy to combat drug abuse.⁷⁸

Of the two, the 1972 Act contains the more detailed provisions upon confidentiality.⁷⁹ For any patient, it protects the confidentiality of records of identity, diagnosis, prognosis, and treatment which are maintained in connection with the performing of any drug abuse function under the 1972 Act, subject to the following exceptions: 1) the patient can consent to a release of the records to medical personnel in order to receive diagnosis or treatment or to governmental personnel in order to receive benefits; 2) the records can be released without patient consent to medical personnel to meet a bona fide medical emergency, or to qualified medical personnel for research purposes so long as individual patients are not identified; 3) contents of the records must be disclosed upon court order after a showing of good cause. In determining whether good cause is present, a court must balance the need for the information against the possible harm of disclosure to the client, to the physician-patient relationship, and to the treatment services.⁸⁰ The 1972 Act continues by providing that other than as specified, no such record may be used to initiate or substantiate any criminal charge against a patient or to conduct investigations of a patient.⁸¹ SAODAP has promulgated detailed regulations for administering the 1972 Act.⁸² Under the regulations, as precautions against breach of confidentiality SAODAP suggests that the records be marked "Confidential" and locked in cabinets marked with the warning:

CONFIDENTIAL PATIENT INFORMATION

Any unauthorized disclosure is a Federal offense.⁸³

The remainder of the regulations implement the provisions of the statute.

Arguably the 1972 Act and existing regulations represent an earnest attempt to provide limited protection to anonymity. Unfortunately, there are four basic flaws in the legislative scheme.⁸⁴ First, the protective pro-

78. *Id.* § 1102.

79. *Id.* § 1175.

80. *Id.* § 1175(b) (2) (C).

81. *Id.* § 1175(c).

82. 21 C.F.R. §§ 1401.01 *et seq.* (1974). These regulations formerly existed as 21 C.F.R. § 401.01 *et seq.* (1973).

83. 21 C.F.R. § 1401.05 (1974).

84. McNamara & Starr, *supra* note 1, at 1602-03, consider that the applicability of the statute and regulations only to federal programs that require a federal license is a deficiency. This flaw, however, is more apparent than real. The confidentiality provisions of the 1972 Act apply to all records of identity, diagnosis, prognosis, or treatment in connection with any drug abuse prevention function assisted under the 1972 Act. 21 U.S.C. § 1175 (Supp. III, 1973). "Drug abuse prevention function" includes any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research. *Id.* § 1103(b). Therefore, application of the 1972 Act is not actually confined to federal programs requiring a federal license as McNamara and Starr asserted.

visions apply only to written records; no attempt is made to protect against disclosure of oral communications.⁸⁵ Second, no procedural safeguards are provided to the patient if his records are made available to law enforcement agents by court order. Thus, a court can issue such a directive after an *ex parte* proceeding upon a showing of good cause for disclosure, with the affected client or treatment program given no opportunity to show that good cause did not exist.⁸⁶ Third, enforcement of the rules is through criminal sanction.⁸⁷ However, since effective enforcement of the statute in general requires detection and prosecution, law enforcement officials may find themselves in something of a dilemma. In seeking to obtain confidential information which may be needed for detection or prosecution, these officials also have a duty to protect confidentiality. As a result, there is at least some reason to doubt that the provisions prohibiting disclosure will be effectively enforced. To remedy this possible deficiency, the statute should contain a provision for private enforcement.⁸⁸ The fourth flaw of the statute exists in that there is no unequivocal imposition of a duty upon all persons not to disclose and not to obtain or attempt to obtain disclosures. A clear statement of this duty, if coupled with a provision for private enforcement, would greatly increase the probabilities that disclosures would not occur.

In an effort to provide better protection against disclosure, SAODAP has proposed new regulations.⁸⁹ First, the suggested security precaution is to be mandatory.⁹⁰ Second, the proposed regulations prohibit infiltration into treatment programs by undercover agents.⁹¹ In addition, the proposals contain a provision proscribing implicit disclosure, by forbidding those in possession of such information from revealing whether a described person is not or had not been a recipient of treatment.⁹² Furthermore, the proposals specifically provide that when disclosure is prohibited by either state or federal law, disclosure is not permitted.⁹³ The proposed regulations would also remedy the problem of a lack of procedural safeguards to disclosure. Under proposed section 1401.63(c)(2), there is a requirement that the patient be notified of any application for a court order to compel

85. McNamara & Starr, *supra* note 1, at 1609.

86. *Id.* See 21 U.S.C. § 1175(b)(2)(C) (Supp. III, 1973).

87. McNamara & Starr, *supra* note 1, at 1610. The 1972 Act provides that one disclosing information in violation of the law shall be fined not more than \$500 for the first offense and not more than \$5,000 for each subsequent offense. 21 U.S.C. § 1175(e) (Supp. III, 1973).

88. It is arguable, however, that the federal statutes can be the basis for the inference of a private right of action. See Section IV A *infra*.

89. Proposed HEW Reg. §§ 1401.01 *et seq.*, 39 Fed. Reg. 30429 (1974).

90. Proposed HEW Reg. § 1401.06.

91. *Id.* § 1401.08.

92. *Id.* § 1401.11.

disclosure. The patient is given an opportunity to appear and be heard and has the right to be represented by counsel.⁹⁴

The proposed regulations, however, do not provide complete protection. The major deficiency appears in proposed section 1401.63,⁹⁵ covering the investigation and prosecution of patients, which permits a court to authorize disclosure of patient records for purposes of investigating or prosecuting a violent crime which the patient is alleged to have committed, if the court is satisfied that certain conditions evincing a high public interest are met.⁹⁶

This proposal, which has no counterpart in the existing regulations, is both confusing and self-defeating. If the purpose of confidentiality is to encourage enrollment in voluntary treatment programs and client cooperation in all such programs, anonymity must be protected. Yet these provisions assume that the patient's identity is known. The proposed regulation would permit disclosure of a patient's records when it has been alleged that he has committed a crime.⁹⁷ Hence, a request for such records could only be made if it were known that the suspect was a participant in a treatment program. As a result, it would appear that anonymity is not protected because at least identification of the client can be compelled without satisfying the criteria in the proposed regulation. This, then, does nothing to further the goal and purpose of confidentiality. Moreover, if enrollment is to be encouraged, the addict must be assured that his participation in a program cannot lead to disclosure of information to law enforcement officials or any other group which data would not be available were the addict not enrolled in the program. Permitting disclosure of treatment records, even if made only after strict criteria are met, makes such assurances impossible. Therefore, in this respect, the proposed regulations fall short of the desired goal.

94. *Id.* § 1401.63(c) (2).

95. *Id.* § 1401.63.

96. The regulation would provide that a [C]ourt may authorize disclosure of records pertaining to a patient for the purpose of conducting an investigation of or a prosecution for a crime which the patient is alleged to have committed only if the court finds that all of the following criteria are met:

(1) There is sufficient evidence to establish probable cause that the patient committed the crime.

(2) The crime involved kidnapping, homicide, assault with a deadly weapon, rape, or other acts causing or directly threatening loss of life or serious bodily injury.

(3) There is a reasonable likelihood that the records in question will disclose material information or evidence of substantial value in connection with the investigation or prosecution.

(4) There is no other practicable way of obtaining the information or evidence.

(5) The actual or potential injury to physician-patient relationship in the program affected and in other programs similarly situated, and the actual potential harm to the ability of such programs to attract and retain patients is outweighed by the public interest in authorizing the disclosure sought.

Id.

In contrast to the relatively detailed provisions on confidentiality contained in the 1972 Act, section 502 of the 1970 Act merely states:

The Attorney General may authorize persons engaged in research to withhold the names and other identifying characteristics of persons who are the subjects of such research. Persons who obtain this authorization may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding to identify the subjects of research for which such authorization was obtained.⁹⁸

Workers in methadone treatment centers are among those considered "persons engaged in research," and clients are considered research subjects.⁹⁹

Reading the 1970 Act and the 1972 Act together raises the obvious question of how a directive from the Attorney General prohibiting disclosure under the 1970 Act effects an attempt to obtain patient records through a court order under the 1972 Act. This issue was litigated in *People v. Newman*.¹⁰⁰ In that case, the police, through a subpoena duces tecum, tried to compel Dr. Newman, a methadone treatment center director, to disclose pictures of treatment clients¹⁰¹ so that the witness to a killing could identify the assailant, whom she believed was a participant with her in Dr. Newman's treatment program. Dr. Newman refused to release the pictures, arguing that as a result of instructions from the Attorney General, the 1970 Act prevented him from doing so.¹⁰² The district attorney contended that the 1972 Act applied and that under it a director of a methadone maintenance program could be compelled under court order to produce records. Thus, the issue, as framed by the court, was "whether the 1972

98. 21 U.S.C. § 872(c) (1970). The Secretary of Health, Education, and Welfare (HEW) has the same powers that Section 502 gives to the Attorney General. 42 U.S.C. § 242(a) (1970).

99. See 21 U.S.C. §§ 802(2), 872(a) (1970).

In an amicus curiae brief filed in *People v. Newman*, 32 N.Y.2d 380, 298 N.E.2d 651, 345 N.Y.S.2d 502 (1973), *cert. denied*, 414 U.S. 1163 (1974), HEW and SAODAP noted:

Methadone Maintenance Treatment Programs are "the most important drug addiction research programs presently in existence" and that their "long range success depends on the ability of each program director to promise each participant *unconditionally*, that his participation in the program will not be disclosed" *Id.* at 388, 298 N.E.2d at 656, 345 N.Y.S.2d at 508 (emphasis added).

100. 32 N.Y.2d 380, 298 N.E.2d 651, 345 N.Y.S.2d 502 (1973), *cert. denied*, 414 U.S. 1163 (1974). The *Newman* decision is also important with regard to the use of the physician-patient evidentiary privilege. See notes 152-60 and accompanying text *infra*.

101. Photographs of each client were taken upon his or her admission to the program. Staff members were to check the photographs before dispensing methadone to ensure that only enrollees received the drug and that each client received the proper dosage. 32 N.Y.2d at 381, 298 N.E.2d at 653, 345 N.Y.S.2d at 503.

102. *Id.* at 382-83, 298 N.E.2d at 653, 345 N.Y.S.2d at 504. The Attorney General of the United States, pursuant to section 502 of the 1970 Act, 21 U.S.C. § 872(c) (1970), had sent a letter to Dr. Newman authorizing the doctor to withhold the names and other identifying information about research subjects. The letter read in part: "You may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative or other proceeding to identify the subjects of such research." 32 N.Y.2d at 386 n.5, 298 N.E.2d at 655 n.5, 345 N.Y.S.2d at 507 n.5.

Act repealed the 1970 Act insofar as the confidentiality of a patient's record is concerned."¹⁰³ The New York Court of Appeals held that the 1970 Act retained vitality and controlled to prohibit disclosure.¹⁰⁴ Accordingly, the court reversed the holding below that Dr. Newman was in contempt of court for failure to comply with the subpoena.¹⁰⁵

The Court of Appeals based its decision upon four factors. First, pursuant to the 1970 Act, the Attorney General and the Secretary of Health, Education and Welfare, even after the 1972 Act took effect, had exercised the power to authorize persons engaged in drug research to withhold information identifying their clients.¹⁰⁶ Apparently, in the court's opinion this indicated that those charged with administering the 1970 Act interpreted the 1972 Act as complementing rather than superseding the 1970 Act. Second, the court focused upon the language of a regulation, promulgated under the 1972 Act, which stated:

Nothing in either the language or the legislative history of the [1972] Act indicates any intent on the part of Congress to amend the [confidentiality] provisions of the 1970 Act or to reduce the protection which can be afforded under them.¹⁰⁷

Third, the court noted the difference between the scope of each of the acts. According to the *Newman* court, the 1970 Act was designed

to help ensure the success of drug research programs in which addict participants require anonymity. . . . A similar guaranty was not . . . necessary in the 1972 Act because that statute covered a wide range of programs and activities in which absolute confidentiality was not required as a prerequisite to successful operation of the programs.¹⁰⁸

Under this view of the purpose of the respective Acts, the court reasoned that the 1972 Act provisions on confidentiality did not authorize disclosure when disclosure was prohibited under the 1970 Act. When, however, the 1970 Act did not apply, because the program involved was not a drug research program, the confidentiality provisions of the 1972 Act governed to provide some, albeit not absolute, protection against disclosure.¹⁰⁹ The final factor relied upon by the court was the established rule of construction that "unless there is clear legislative design to repeal or modify an earlier piece of legislation . . . we must if at all possible, give full effect to both

103. 32 N.Y.2d at 384, 298 N.E.2d at 654, 345 N.Y.S.2d at 505.

104. *Id.* at 389, 298 N.E.2d at 657, 345 N.Y.S.2d at 509.

105. *Id.* at 390, 298 N.E.2d at 657, 345 N.Y.S.2d at 510.

106. *Id.* at 386-87, 298 N.E.2d at 655, 345 N.Y.S.2d at 507, *citing* 37 Fed. Reg. 24639 (1972).

107. 32 N.Y.2d at 387, 298 N.E.2d at 655, 345 N.Y.S.2d at 507, *citing* 37 Fed. Reg. 24639 (1972).

108. *Id.* at 387, 298 N.E.2d 655-56, 345 N.Y.S.2d at 508. The court used drug abuse educational programs and job training programs for medical aides as examples of the types of programs covered by the 1972 Act which did not require confidentiality. *Id.*

statutes."¹¹⁰ Finding no such evidence in the 1972 Act, the court stated that no repeal could be implied.¹¹¹

One important issue regarding the relationship between the two acts was not resolved in *Newman* — whether a research program that would fit within the scope of both acts could utilize the protection afforded by the 1972 Act; that is, can the 1972 Act be used to protect confidentiality when the 1970 Act would be ineffective in doing so? The importance of this issue can be illustrated through a hypothetical situation based upon the *Newman* facts. Suppose that New York police officers went to Dr. Newman and asked him to disclose the *identities* of treatment clients so that the clients might be protected from being approached by drug dealers who might seek to entice the clients to leave the program and renew their heroin use. This scheme would both protect clients and aid the police in identifying drug dealers. Suppose further that Dr. Newman thought that this was a good idea and wanted to disclose the information. Under the 1970 Act, he would be permitted to disclose,¹¹² but according to the 1972 Act, such disclosure would violate the law.¹¹³ This situation illustrates the important differences between the 1970 and 1972 Acts. Under the 1970 Act only compulsory disclosure is prohibited,¹¹⁴ that is, the police in the hypothetical situation could not lawfully force Dr. Newman to reveal the clients' names. Voluntary disclosure, however, is prohibited by the 1972 Act.¹¹⁵ Moreover, the former operates to prohibit compulsory disclosures only in formal proceedings.¹¹⁶ Thus, in the hypothetical situation, the 1970 Act could not prohibit compelled disclosure to the police so long as the information were not used in a proceeding. Under the 1972 Act, however, no disclosure, voluntary or compulsory, could be made, regardless of whether or not the information were to be used in a proceeding, subject, of course, to the exceptions set out in the 1972 Act itself.¹¹⁷ Therefore, circumstances could exist that would make use of the 1972 Act protections preferable to use of those in the 1970 Act.

Upon this particular issue, *Newman* is susceptible to two interpretations. The first is that when a 1970 Act program is involved only the 1970 Act safeguards apply, thereby precluding a 1970 Act program from utilizing 1972 Act protections. This interpretation is supported by the

110. *Id.* at 389, 298 N.E.2d at 657, 345 N.Y.S.2d at 509.

111. *Id.*

112. This is so because the 1970 Act empowers the Attorney General to authorize merely the withholding of information. The Act confers no power upon the Attorney General to prohibit disclosure. *Cf.* 21 U.S.C. § 872(c) (1970). *See* text accompanying note 98 *supra*.

113. The 1972 Act prohibits disclosure subject to stated exceptions. 21 U.S.C. § 1175(a) (Supp. III, 1973). *See* notes 79-83 and accompanying text *supra*.

114. 21 U.S.C. § 872(c) (1970).

115. *Id.* § 1175(a), (c) (Supp. III, 1973).

116. *Id.* § 872(c) (1970).

117. *Id.* § 1175 (Supp. III, 1973).

differences between the scope of the 1970 and the 1972 Acts.¹¹⁸ If each applies to a different program and serves a different purpose, the argument can be made that no one program can utilize the protection of both acts. The second interpretation is that the two acts complement each other: if confidentiality is protected by either act, disclosure is prohibited. This latter view is the more cogent, because of the basic philosophy behind both acts, that of fostering a medical solution to the drug abuse problem by encouraging addicts to seek and cooperate with treatment methods.¹¹⁹ Treatment is encouraged by protecting confidentiality and anonymity. Therefore, if the program fits within the coverage of the act, that particular act can be used to protect anonymity, regardless of whether the other act would fail to offer such protection. As a result, both acts would accomplish their intended purposes much more effectively.

IV. POSSIBLE SOURCES OF AN ADDICT'S PERSONAL RIGHT TO CONFIDENTIALITY

Having outlined the primary threats to addict anonymity and confidentiality, and the apparent inadequacy of those statutes and regulations designed to meet this problem, it is clear that some additional safeguards are necessary. One effective method might be to give the addict the right to protect his anonymity and confidentiality of records by resorting to the judicial system. The remainder of this Comment will briefly discuss five legal theories upon which such a right could be premised. None of these theories has been judicially approved, but each of them can be derived from presently accepted legal concepts.

A. *Implied Cause of Action for Statutory Violations*

An individual within the class intended to be protected by a statute may, at times, have a right to enforce the statute in a civil action, despite the absence of an express statutory provision for private enforcement.¹²⁰

118. See text accompanying note 108 *supra*.

119. See text accompanying notes 77 & 78 *supra*.

120. See Comment, *Private Remedies Under the Consumer Fraud Acts: The Judicial Approaches of Statutory Interpretation and Implication*, 67 NW. U.L. REV. 413 (1972), for a discussion of private enforcement of consumer fraud statutes.

The concept that a cause of action could be inferred from a federal regulatory statute was first approved by the Supreme Court in *Texas & Pac. Ry. v. Rigsby*, 241 U.S. 33 (1916), in which the Court stated that the Federal Safety Appliance Act, 27 Stat. 531 (1893), implied the right to recover damages by one sustaining a loss occasioned by violation of the act, if the individual was a member of the class "for whose especial benefit the statute was enacted" 241 U.S. at 39. See Comment, *Implying Civil Remedies from Federal Regulatory Statutes*, 77 HARV. L. REV. 285, 285-86 (1963) [hereinafter cited as *Civil Remedies*] for a discussion of other regulatory laws under which a civil remedy has been implied.

Note that two remedies could be inferred from a regulatory law in the addict-confidentiality context: a cause of action for damages for improper disclosure or a right to sue to enjoin improper disclosure.

Theoretically, the inference of a civil remedy from a regulatory statute can be justified in one of two ways. One view is that the statute establishes a standard of conduct, breach of which is actionable if the action resulted in an injury to one whom the statute was intended to protect.¹²¹ The other is that the statute prohibits certain conduct, and if one acts in contravention of the statute, the court will act as lawmaker and create a new cause of action in favor of the injured party.¹²² Perhaps the most compelling arguments in favor of recognizing a civil remedy are in the words of one commentator:

[I]mplying a cause of action may increase the likelihood of compliance with the statute by giving victims incentive to assist in its enforcement and potential violators, faced with an additional penalty, added reason to conform their conduct to it. The implied cause of action can also provide direct relief for members of a class that the legislature wished to protect.¹²³

To determine whether a remedy should be inferred requires an analysis of the relationship between the provisions of the statute involved and the goal of the lawmakers in enacting it. Such a right of action could be found to be implicit in a state statute, such as section 8 of the Pennsylvania Drug and Alcohol Act which mandates confidentiality,¹²⁴ or in a federal statute. For example, section 408(e) of the 1972 Act provides for the confidentiality of the records of clients and imposes fines if these provisions are violated.¹²⁵ The purpose of the confidentiality provisions can be gleaned from their legislative history. One aim of the 1972 Act was to combat drug abuse through medical methods, and the assurance of confidentiality was viewed as a necessity in meeting this goal.¹²⁶ As

121. See *Civil Remedies*, *supra* note 120, at 286.

122. *Id.*

123. *Id.* at 291. Victims of a violation of the confidentiality provisions of a drug act would not need an incentive to assist in enforcement, but they would need a method enabling them to assist in enforcement.

124. PA. STAT. ANN. tit. 71, § 1690.108 (Supp. 1972). See note 48 *supra*.

125. Section 408(e) provides:

Except as authorized under subsection (b) of this section, any person who discloses the contents of any record referred to in subsection (a) of this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

21 U.S.C. § 1175(e) (Supp. III, 1973).

126. The House-Senate conferees stated:

The conferees wish to stress their conviction that the strictest adherence to the provisions of this section [on confidentiality] is absolutely essential to the success of all drug abuse prevention programs. Every patient and former patient must be assured that his right to privacy will be protected. Without that assurance, fear of public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment they must have if this tragic national problem is to be overcome.

Every person having control over or access to patients' records must understand that disclosure is permitted only under the circumstances and conditions set forth in this section. Records are not to be made available to investigators

noted previously in this Comment,¹²⁷ due to the fact that the confidentiality provisions are enforced through criminal sanctions, law enforcement officers face a possible conflict of interest in investigating and prosecuting drug-related crimes and insuring compliance with the 1972 Act. Consequently, an addict willing to enroll in a treatment program cannot be guaranteed that these confidentiality provisions will be vigorously enforced. As a result, there can be no guarantee that enrollment in the program will not create a source of information about the addict that would otherwise be unavailable. To rectify this, an individual who is wronged as a result of a violation of the confidentiality provisions should have the right to enforce the statute through a civil action against the wrongdoer. With knowledge that such protection exists, an addict would be more willing to undergo treatment.

A recent example of a judicial creation of a private right of action from a federal regulatory statute is *Stewart v. Travelers Corp.*¹²⁸ where the Ninth Circuit held that the penal provision of the Consumer Credit Protection Act,¹²⁹ which imposes penalties upon the employer in the event of the discharge of an employee due to garnishment of wages for his indebtedness, implied a cause of action in favor of an employee so discharged.¹³⁰ The court stated that absent "a clear congressional intent to the contrary, the courts are free to fashion appropriate civil remedies, based on the violation of a penal statute where necessary to ensure the full effectiveness of the congressional purpose."¹³¹ The *Stewart* court relied in part upon *Wyandotte Trans. Co. v. United States*.¹³² In that case the Supreme Court had declared that where the interest the plaintiff asserts is within the class that the statute was intended to protect, the harm alleged is within the type the statute was intended to prevent, and the statutory criminal penalties are inadequate to fully protect the asserted interest, a civil action for damages arises by implication.¹³³

It is submitted that applying the *Wyandotte* standards to the situation of an addict whose right to confidentiality has been violated would result in the recognition in the addict of a civil remedy. The confidentiality provisions were intended to protect addicts and the harm to be prevented was disclosure of information. Regarding the question of the adequacy of the

for the purpose of law enforcement or for any other private or public purpose or in any manner not specified in this section.

H.R. REP. No. 920, 92d Cong., 2d Sess. 33 (1972).

127. See notes 87 & 88 and accompanying text *supra*.

128. 503 F.2d 108 (9th Cir. 1974).

129. 15 U.S.C.A. § 1674 (1974).

130. 503 F.2d at 109.

131. *Id.* at 110, quoting *Burke v. Compania Mexicana de Aviccion*, 433 F.2d 1031, 1033 (9th Cir. 1970).

132. 389 U.S. 191 (1967).

133. *Id.* at 202. In *Wyandotte*, the Court held that the remedies for violation of section 15 of the Rivers and Harbors Act of 1899, 33 U.S.C. § 409 (1970), which imposed upon a shipowner the duty to mark a sunken ship, were not exclusive. 389

remedies expressly provided for in the statute, the *Stewart* court said that the question is whether the statute's protection might be enhanced by allowing private civil relief.¹³⁴ Here, private civil relief would enhance the statute's effectiveness by compensating the addict for his injury, thereby encouraging compliance with the confidentiality provisions. Hence, treatment programs could give addicts assurances that their rights to confidentiality will not be violated. An additional consideration is that the existing statutory penalty would in no way compensate the addict for the violation of his right.¹³⁵ Thus, a civil remedy should be implied.¹³⁶

B. *Privileged Communications*

The privileged communications theory, upon which an addict could base an argument that he has a right to prohibit disclosure of information about himself, springs from a physician-patient, psychotherapist-patient, psychologist-patient, or social worker-client privilege.¹³⁷ A brief analysis of these privileges as they exist in California, Massachusetts, New York, and Pennsylvania may be helpful in revealing how the privileges operate as background for a discussion of the protection they can afford confidentiality.

1. *California*

California makes privileged a communication between a physician or psychotherapist and a patient,¹³⁸ which gives the patient, physician, or

134. 503 F.2d at 112.

135. Violators of the confidentiality provisions of the 1972 Act face mandatory fines of not more than \$500 for the first offense and not more than \$5000 for each subsequent offense. 21 U.S.C. § 1175(e) (Supp. III, 1973).

136. The Supreme Court recently refused to infer a private cause of action for a violation of section 610 of the Federal Election Campaign Act, 18 U.S.C. § 610 (1970), as amended, (Supp. III, 1973). *Cort v. Ash*, 95 S. Ct. 2080 (1975). Although *Ash* may indicate a reluctance on the part of the Court to infer a cause of action for violations of federal statutes, it did not preclude the possibility of these actions. The *Ash* Court noted that private causes of action have been inferred where there was "a pervasive legislative scheme governing the relationship between the plaintiff class and the defendant class in a particular regard." *Id.* at 2090. For additional discussion upon the issue of the implication of civil remedies from federal statutes, see the cases and materials cited in 503 F.2d at 109-10 nn.3-6, and Note, 20 VILL. L. REV. 615 (1975).

137. Whitford, *The Physician, The Law, and The Drug Abuser*, 119 U. PA. L. REV. 933 (1971). Whitford argues for the adoption of such a privilege to protect drug users in order to foster a medical solution to the problem of drug abuse. *Id.* at 938. Note that the Federal Rules of Evidence contain no provision for a general physician-patient privilege. See FED. R. EVID. 501.

138. A "confidential communication between patient and physician" includes: information obtained by an examination of the patient, transmitted between a patient and his physician in the course of that relationship and in confidence by means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which

psychotherapist the right to refuse to disclose of such a communication.¹³⁹ The term "psychotherapist" includes psychiatrist, psychologist, and clinical social workers.¹⁴⁰

Although the physician-patient and psychotherapist-patient provisions would appear to protect the anonymity of an addict enrolled in a treatment program and to preserve the confidentiality of information communicated to the program staff, they in fact offer only limited protection because the privilege is deemed not to exist in criminal proceedings.¹⁴¹ Because the real value of the privilege to the addict exists in the criminal proceeding, the addict is thus denied the benefit of this privilege in the situation in which it would be most useful. Moreover, there is no privilege as to information which *must* be reported to a public employee.¹⁴² Therefore, under California's statute which requires treatment programs to inform state officials of the names of patients,¹⁴³ no physician-patient privilege would exist.

2. *Massachusetts*

In Massachusetts, the relevant provisions for privileged communications are not so elaborate. While Massachusetts provides for no general physician-patient privilege, a psychotherapist-patient privilege does exist.¹⁴⁴ A psychotherapist is a licensed physician who devotes a substantial portion of his time to the practice of psychiatry.¹⁴⁵ Privileged communications include matters of diagnosis and treatment, and the privilege can be asserted

the physician is consulted, and includes a diagnosis made and the advice given by the physician in the course of that relationship.

CAL. EVID. CODE § 992 (West Supp. 1974). The definition relevant to the psychotherapist-patient relationship is identical, except that "psychotherapist" is used instead of "physician." *Id.* § 1012.

139. *Id.* § 994 (physician-patient); *id.* § 1014 (psychotherapist-patient).

140. "Psychotherapist" is defined as:

- (a) A person authorized, or *reasonably believed by the patient to be authorized*, to practice medicine in any state or nation who devotes, or is *reasonably believed by the patient to devote*, a substantial portion of his time to the practice of psychiatry;
- (b) A person licensed as a psychologist under . . . the Business and Professions Code;
- (c) A person licensed as a clinical social worker under . . . the Business and Professions Code, when he is engaged in applied psychotherapy of a non-medical nature.

Id. § 1010 (emphasis added). Under these provisions and those relating to social workers, CAL. BUS. & PROF. CODE §§ 9041, 9042, 9049, 9052, 9054, 9056 (West Supp. 1974), it is likely that most treatment programs will have a "psychotherapist" working in or at least consulting with the program.

141. CAL. EVID. CODE § 998 (West 1966) (physician-patient); *id.* § 1028 (West Supp. 1974) (psychotherapist-patient).

142. *Id.* § 1006 (West 1966) (physician-patient); *id.* § 1026 (psychotherapist-patient).

143. CAL. HEALTH & SAFETY CODE § 11221 (West Supp. 1974). See note 19 *supra*.

144. MASS. GEN. LAWS ANN. ch. 233, § 20B (West Supp. 1975).

in "any court proceeding and in any proceeding preliminary thereto and in legislative and administrative proceedings" ¹⁴⁶

3. *New York*

In New York, communications between physician-patient,¹⁴⁷ psychologist-patient,¹⁴⁸ social worker-client¹⁴⁹ may be privileged. The physician-patient privilege provides:

Unless the patient waives the privilege, a person authorized to practice medicine, . . . nursing or dentistry shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity.¹⁵⁰

The privilege is testimonial and operates in all proceedings in which an individual may be compelled to testify under oath.¹⁵¹

This particular provision was interpreted in *People v. Newman*,¹⁵² where the Court of Appeals of New York held, in addition to what was the proper interpretation of the federal acts,¹⁵³ that the physician-patient privilege did not apply to preclude disclosure of pictures upon the program records of methadone treatment clients.¹⁵⁴ The court reasoned that under the statute, only information "acquired in attending a patient in a professional capacity" was privileged.¹⁵⁵ The photographs, the court stated, were obtained by Dr. Newman's staff during administrative admission procedures.¹⁵⁶ The court also relied upon New York case law which had established that facts about a patient which may be plainly observed or easily obtained by a layman were not privileged.¹⁵⁷ Because the patient's physical appearance fit this exception, the privilege could not prevent disclosure.¹⁵⁸

The *Newman* decision can be criticized because it is contrary to the national policy of promoting a medical solution to the problem of drug abuse.¹⁵⁹ In the treatment context, it is the identity of the client which

146. *Id.*

147. N.Y. CIV. PRAC. LAW § 4504 (McKinney Supp. 1974).

148. *Id.* § 4507.

149. *Id.* § 4508.

150. *Id.* § 4504(a).

151. *Id.*

152. 32 N.Y.2d 397, 298 N.E.2d 651, 345 N.Y.S.2d 502 (1973), *cert. denied*, 414 U.S. 1163 (1974).

153. See notes 110 & 111 and accompanying text *supra*.

154. 32 N.Y.2d at 398-99, 298 N.E.2d at 653-54, 345 N.Y.S.2d at 503-04.

155. *Id.*

156. *Id.* at 383, 298 N.E.2d at 653, 345 N.Y.S.2d at 505.

157. *Id.*, citing, e.g., *Klein v. Prudential Ins. Co.*, 221 N.Y. 449, 117 N.E. 942 (1917).

158. 32 N.Y.2d at 398-99, 298 N.E.2d at 653-54, 345 N.Y.S.2d at 503-04. The contempt judgment was reversed upon other grounds. See notes 103-08 and accompanying text *supra*.

159. See text accompanying notes 170-73 *supra*.

must remain confidential if enrollment is to be encouraged. Thus, the confidential communication consists of the client's identity; to label this communication mere administrative information not privileged under the law is to defeat the purpose of making the privilege theory available to the client.¹⁶⁰

In any event, the apparently destructive effect of *Newman* upon confidentiality may be mitigated if the decision is limited to its facts. In *Newman* the photographs were to be shown only to the witness to the killing, so that she could identify the assailant. Because the witness had recognized the assailant as one of the people enrolled in her own treatment program, to allow her to view the photographs merely to discover his name would in no way imperil the anonymity of treatment clients. Furthermore, disclosure was sought not to identify the client as a drug addict, but to identify him as a suspected murderer. Since there is a great public interest in identifying and apprehending murderers, it can be argued that *Newman* merely stands for the proposition that the overriding public interest in identifying and apprehending murderers justified the disclosure. Thus, it is possible that in New York, the physician-patient privilege survives in the context of addict-patient confidentiality even after *Newman*.

Newman concerned only the statute regarding the physician-patient privilege. The privilege in other relationships is governed by other statutes. If the treatment center employs or is directed by a registered psychologist, or if the addict consults a registered psychologist, the addict client effectively can claim the benefit of the attorney-client privilege, because New York law places the psychologist-client privilege upon the same footing as the attorney-client privilege.¹⁶¹ Use of the attorney-client privilege would be particularly helpful to an addict wishing to preserve his anonymity, since the client's identity can be privileged against disclosure.¹⁶² With respect to communications between an addict and social worker, the statute states that if the treatment program employs or is directed by,

160. McNamara and Starr, *supra* note 1, at 1600.

161. The law provides:

The confidential relations and communications between a [registered] psychologist . . . and his client are placed on the same basis as those provided by law between attorney and client, and nothing in such article shall be construed to require any such privileged communications to be disclosed.

N.Y. CIV. PRAC. LAW § 4507 (McKinney Supp. 1974).

162. See *Tierney v. Flower*, 32 App. Div. 2d 392, 302 N.Y.S.2d 640 (1969), in which a child's natural mother sought to compel the attorney who had represented the child's adoptive parents in the adoption arrangements to disclose the names and addresses of his clients. The court compelled disclosure but stated that when disclosure of identity is sought the public interest must be weighed against the injury that would be done to the attorney-client relationship. *Id.* at 395, 302 N.Y.S.2d at 643. In *Tierney*, concern for the child's welfare outweighed the slight damage that would be done to the attorney-client relationship. In a psychologist-patient context, the public benefit would have to be weighed against the very strong interest in allowing a drug addict to continue to have the confidence in his psychologist necessary to a medical solution to the addiction problem.

or if the addict otherwise consults one who is, a certified social worker,¹⁶³ the communication is privileged, although not in the same sense as a communication between attorney and client.¹⁶⁴

4. *Pennsylvania*

Pennsylvania law is similar. If the treatment center employs or is directed by, or if the addict otherwise consults, a licensed psychologist, the addict-client can claim a privilege equal to the attorney-client privilege.¹⁶⁵ The advantage of using the attorney-client privilege is more uncertain in Pennsylvania than in New York, however, in that no case has discussed whether the identity of the client can be privileged against disclosure.

5. *Summary*

Given the law of privileged communications, it remains to be seen how the privilege theory can be useful in protecting an addict. Unlike a civil remedy inferred from a regulatory statute, the privileged communications theory can be used as a shield but not as a sword. The privilege is largely testimonial, and may be invoked only in a judicial proceeding of some type. While the protection thus offered is limited, it is not without value. One benefit is that the physician treating a drug-addicted or drug-dependent person may feel less reluctant to assure an addict that no information will be disclosed and more confident about refusing to disclose the information to one requesting it than he otherwise would be, thereby denying to present or prospective employers and law enforcement officers a source of information that could imperil the patient's employment or community position. Moreover, assuming that law enforcement officers do obtain information with which to commence harassing prosecutions, the information obtained from a physician, psychotherapist, psychologist, or social worker would not be admissible if the privilege applies in criminal proceedings. Therefore, the privileged communications theory might be one source of protection for an addict.¹⁶⁶

163. N.Y. EDUC. LAW §§ 7702-04 (McKinney 1974), provides a definition of a certified social worker.

164. N.Y. CIV. PRAC. LAW § 4508 (McKinney Supp. 1974).

165. PA. STAT. ANN. tit. 63, § 1213 (Supp. 1974). The provisions about the attorney-client privilege state:

Nor shall counsel be competent or permitted to testify to confidential communications made to him by his client, or the client be compelled to disclose the same, unless in either case this privilege be waived upon the trial by the client.

PA. STAT. ANN. tit. 19, § 686 (1964) (criminal proceedings); PA. STAT. ANN. tit. 28, § 321 (1958) (civil proceedings).

B. Privacy

Arguably, an addict enrolled in a drug treatment program can premise a right to anonymity upon a general right to privacy. The argument can take one or two forms: first, testimonial disclosure violates the addict's constitutional right to privacy; second, any unauthorized disclosure is an invasion of privacy, giving the addict a cause of action in tort.

1. Constitutional Right to Privacy

The modern theories¹⁶⁷ about the existence of a constitutional right to privacy are primarily based upon two cases: *Griswold v. Connecticut*,¹⁶⁸ and *Roe v. Wade*.¹⁶⁹ In *Griswold*, the Supreme Court of the United States held invalid, as an unconstitutional invasion of a married person's privacy, a Connecticut statute which made criminal the use of contraceptives.¹⁷⁰ The Court declared that the Constitution created zones of privacy which included the first amendment right to privacy in association,¹⁷¹ the third amendment right to refuse to quarter soldiers in peacetime, the fourth amendment right to be "secure, in their persons, houses, papers, and effects, against unreasonable searches and seizures," the fifth amendment right to refuse to testify against oneself, and a possible ninth amendment right to privacy which is retained by an individual because it is not elsewhere limited in the Constitution.¹⁷²

In *Roe*, the Court held, *inter alia*, that the constitutional right to privacy encompassed a woman's right to decide, until a certain time in her pregnancy, whether or not to terminate her pregnancy. The *Roe* Court recognized the right to privacy as fundamental and stated that it was in

167. The right to privacy as known in the United States dates to 1890. Warren & Brandeis, *The Right of Privacy*, 4 HARV. L. REV. 193 (1890). Recently, different commentators have described the right in various ways. It has been stated that [c]onfidentiality . . . refers to one person's duty not to reveal information about another person without the person's consent. The second person has a correlative right to insist that this information not be disclosed.

The individual employee's right to privacy of his personal information is invaded twice in the process of collecting and keeping personnel data: [in collection and in dissemination].

Mironi, *The Confidentiality of Personal Records: A Legal and Ethical View*, 25 LAB. L.J. 270, 271-72 (1974). Another commentator has stated that the essence of privacy is no more, and certainly no less, than the freedom of the individual to pick and choose for himself the time and circumstances under which, and most importantly, the extent to which, his attitudes, beliefs, behavior and opinions are to be shared with or withheld from others. Countryman, *The Diminishing Right of Privacy: The Personal Dossier and the Computer*, 49 TEXAS L. REV. 837, 868 (1971), quoting Ruebhausen & Brim, *Privacy and Behavioral Research*, 65 COLUM. L. REV. 1184, 1189 (1965).

168. 381 U.S. 479 (1965).

169. 410 U.S. 113 (1973).

170. 381 U.S. at 485.

171. *Id.* at 483 citing NAACP v. Alabama, 357 U.S. 449 (1958).

172. 381 U.S. at 484.

part based upon the fourteenth amendment concepts of personal liberty and restriction upon state action.¹⁷³ Because the *Roe* Court stated merely that the right to privacy extended to activities relating to marriage, procreation, contraception, family relationships, child rearing, and education,¹⁷⁴ the first question in determining whether the right can be utilized by a treatment program client is whether this concept can be extended to encompass a right to keep medical records confidential and a right to protect anonymity. An argument for extension is that drug abuse treatment relates to an addict and his body as intimately and personally as termination of a pregnancy relates to a woman and her body.

One pre-*Roe* decision suggests that such an extension cannot be made. In *Felber v. Foote*,¹⁷⁵ a federal district court addressed the issue of whether a constitutional right to privacy protected a psychiatrist against having to disclose the identity of a drug dependent, deciding that no such right existed to protect against invasions of the physician-patient relationship.¹⁷⁶ The plaintiff sought declaratory and injunctive relief from enforcement of a state statute which compelled "practitioners of the healing arts" to name and report other information about drug dependent persons to the state.¹⁷⁷ According to the statute, the information in the reports would not be admissible in judicial proceedings, the information was to remain confidential, and it would not be used for any purpose other than rehabilitation, statistical analysis, or medical treatment.¹⁷⁸ The plaintiff premised his suit upon the Civil Rights Act of 1871,¹⁷⁹ claiming that the reporting statute represented an unconstitutional deprivation of the physician's right to privacy. First, the plaintiff argued that the statute interfered with his private practice in three ways: 1) by imposing a duty to disclose, the statute created a conflict with his professional duty to his patient to keep communications confidential; 2) because he would be forced to report any information requested or reveal the duty to disclose to his patients before offering treatment, his patients might choose to decline treatment; and 3)

173. 410 U.S. at 153. If privacy were viewed as a fundamental right, restrictive state legislation could only be justified by a compelling state interest. *Id.* at 155.

174. *Id.* at 152-53.

175. 321 F. Supp. 85 (D. Conn. 1970).

176. *Id.* at 90.

177. The statute provides:

Each practitioner of the healing arts shall report to the commissioner of health the full name, address and date of birth of every person who, in his opinion is a drug-dependent person dependent upon controlled drugs. . . . Practitioners making such reports in good faith shall be immune from any civil or criminal liability that otherwise might be incurred from the making of such report. No such report or the information therein shall be admissible in any criminal prosecution or used for other than rehabilitation, statistical or medical purposes and each such report shall be held confidential by the commissioner.

CONN. GEN. STAT. ANN. § 19-48a (1969).

178. *Id.*

179. 42 U.S.C. § 1983 (1970). Jurisdiction was based upon 28 U.S.C. § 1343(3) (1970).

the statute might require licensed physicians to violate standards of professional ethics.¹⁸⁰ The plaintiff's second contention was that the unique nature of the doctor-patient relationship afforded a physician a "constitutionally protected right to privacy in his conduct of [the doctor-patient] relationship."¹⁸¹ The court rejected all these arguments, quoted *Katz v. United States*,¹⁸² wherein the Supreme Court stated that "there is no general constitutional right to privacy,"¹⁸³ and reasoned that the concept of privacy propounded by the plaintiff was not analogous to any zone of privacy which had previously been granted constitutional protection.¹⁸⁴ With respect to the *Griswold* decision, the *Felber* court stated that in protecting "the sanctity of the family," the Court had not indicated an intention "to constitutionalize the privacy of other relationships, specifically that of physician and patient."¹⁸⁵

Although the *Felber* court faced only a psychiatrist's claim of a right to privacy, it would appear that the court would have reached the same result had a prospective patient brought the same action, especially in light of the court's statement concerning the privacy of the physician-patient relationship. However, the validity of *Felber* may be in question in light of *Roe*. Drug abuse treatment could be considered such a personal matter that, under *Roe*, there is a constitutional right against the state intrusion into this matter which a reporting statute would entail.

The *Felber* situation should be contrasted to that in *Merriken v. Cressman*.¹⁸⁶ In *Merriken*, a Pennsylvania district court held that a drug abuse prevention program designed to aid a school district in identifying potential drug abusers violated the right to privacy of parents with children enrolled in that school district.¹⁸⁷ The program required high school students to answer questions which were "highly personal" and went "directly to an individual's family relationships and his rearing."¹⁸⁸ The court stated that it would look closely at any challenged factual situation that involved family relationships and child rearing. The plaintiff's successful argument was based upon *Griswold* and *Roe*. The factual setting in *Merriken* involved family relationships and child rearing; therefore, *Griswold* and *Roe* provided protection. But it also involved drug abuse pre-

180. 321 F. Supp. at 87.

181. *Id.* at 88.

182. 389 U.S. 347 (1967).

183. *Id.* at 350.

184. 321 F. Supp. at 88.

185. *Id.* at 88-89.

186. 364 F. Supp. 913 (E.D. Pa. 1973).

187. *Id.* at 922.

188. *Id.* at 918. The questionnaires asked about family religion, the race or skin color of the student, and the family composition, including the reason for the absence of one or both parents. The questionnaires also delved into such details of family relationships as whether one or both parents hugged and kissed the child when the child was small, or told the child how much they loved him, or enjoyed talking about current events with the child, or made the child feel loved.

vention. Although *Merriken* can be read as an extension of the zone of privacy doctrine into the drug abuse area, it is readily distinguishable from the *Felber* situation because the information sought in furtherance of the drug abuse prevention program conflicted with the confidentiality of a parent-child relationship and not that of physician-patient.

2. *Tort Action for Invasion of Privacy*

An addict in a treatment program may have a cause of action in tort for invasion of privacy against anyone who disclosed information that revealed his status as an addict. At common law, the cause of action for invasion of privacy exists in four contexts: 1) where another appropriates one's name or likeness for personal advantage; 2) where another intrudes upon one's seclusion or solitude, or into his private affairs; 3) where another publicly discloses embarrassing facts about one's private life; and 4) where another creates publicity that places one in a false light in the public eye.¹⁸⁹ Essential to the cause of action are two elements. The prying or intrusion must be one that would be offensive or objectionable to a reasonable person and it must be into an area that is deemed to be private.¹⁹⁰

In the present context, disclosure of the identity of or information about a treatment client arguably could be a disclosure of embarrassing private facts about that person,¹⁹¹ in that the disclosure, while not a physical prying or intrusion, would be an unauthorized encroachment into a very private area. However, an addict may have difficulty in proving that the information has been published, another necessary element.¹⁹² Evidently, at one time, formal publication in writing to more than just a small group was required for the action to be successful, but the reason for this rule seems to have been that of preventing individuals who had not been damaged from recovering for invasions of privacy.¹⁹³ That the unauthorized disclosure would itself satisfy the publication requirement is probable so long as it results in injury to the addict.¹⁹⁴ Unfortunately, an

189. Mironi, *supra* note 167, at 281. See Prosser, *Privacy*, 48 CALIF. L. REV. 383, 389 (1960).

190. Prosser, *supra* note 189, at 390-91.

191. Note, *Action for Breach of Medical Secrecy Outside the Courtroom*, 36 U. CIN. L. REV. 103, 107 (1967). The author of the Note argues for judicial recognition of a cause of action for breach of confidence to protect against improper disclosure of medical information.

192. Prosser, *supra* note 189, at 393.

193. *Id.* at 393-94.

194. The tentative draft of the *Restatement of Torts, Second*, takes a different view of this issue. It states:

One who gives publicity to matters concerning the private life of another, of a kind highly offensive to a reasonable man, is subject to liability to the other for invasion of privacy.

RESTATEMENT (SECOND) OF TORTS § 652D (Tent. Draft No. 13, 1967). Comment b there distinguishes publication, which includes any communication to a third person,

addict asserting a tort action for invasion of privacy for an unauthorized disclosure would have almost no precedent upon which to rely.

One case, *Horne v. Patton*,¹⁹⁵ does offer support for this theory. In *Horne*, the defendant-physician released information about the plaintiff to the plaintiff's employer, who subsequently discharged the plaintiff.¹⁹⁶ The court held that the trial court erred in sustaining the demurrer to the portion of the complaint in which the plaintiff alleged a cause of action for invasion of privacy,¹⁹⁷ stating:

Unauthorized disclosure of intimate details of a patient's health may amount to unwarranted publication of one's private affairs with which the public has no legitimate concern such as to cause outrage, mental suffering, shame or humiliation to a person of ordinary sensibilities.¹⁹⁸

Nothing would appear to preclude application of this reasoning for the benefit of an addict patient suing his physician for invasion of privacy where the physician had disclosed the patient's identity or status as an addict to a person who had no legitimate concern for the information.¹⁹⁹

Another difficulty that might be encountered in asserting this cause of action is the existence of a statutory exemption from liability for a physician who discloses such information. Indeed, a statute like that discussed in the *Felber* case²⁰⁰ would totally preclude recovery. In spite of these pitfalls, a cause of action in tort for disclosure of confidential information does have validity, at least conceptually. At present, the inadequacy of common law concepts of privacy has prompted the suggestion that there be "recognition of a fifth class within this tort, a class which could be called 'breach of confidence,'" based upon the Hippocratic oath.²⁰¹

from publicity, which takes place when the matter is made public by communication of it to the public at large, or to so many persons that the matter must be regarded as substantially certain to become one of public knowledge. *Id.*, comment *b*.

195. 291 Ala. 701, 287 So. 2d 824 (1973). See notes 208-13 and accompanying text *infra*.

196. 291 Ala. at 709-10, 287 So. 2d at 830-31. The court did not indicate what this information was.

197. *Id.*

198. *Id.* at 709, 287 So. 2d at 830.

199. There are a number of cases other than *Horne* in which courts have recognized a cause of action for invasion of privacy resulting from disclosure of medical information where the information revealed was rather unique. See, e.g., *Barber v. Time, Inc.*, 348 Mo. 1199, 159 S.W.2d 291 (1942) (revelation of patient's capacity for food); *Feeney v. Young*, 191 App. Div. 501, 181 N.Y.S. 481 (1920) (public release of a film of patient's caesarian section operation); *Griffin v. Medical Soc'y of New York*, 7 Misc. 2d 549, 11 N.Y.S.2d 109 (1939) (publication of photographs of patient's "saddle nose").

200. See note 177 *supra*.

201. Note, *supra* note 191, at 109. This note contains an excellent history of the right to privacy as it relates to disclosure of medical information. *Id.* at 107-13.

D. Malpractice (Breach of Fiduciary Relationship)

The argument has been made that the oath taken by physicians is sufficient to protect an addict's anonymity, because, by taking the Hippocratic oath,²⁰² the practitioner vows to keep information communicated in the physician-patient relationship absolutely secret.²⁰³ The requirement of secrecy would be viewed as part of the physician's professional duty and breach of that duty would give rise to a malpractice claim by the patient.²⁰⁴ Alternatively, because physicians take the oath, clients have a reasonable expectation that their communications and indeed their identities will be treated by the physician as confidential. This, then, induces the client to place trust in the physician, and the relationship assumes the characteristics of a fiduciary relationship.²⁰⁵ As a result, disclosure would give the patient

202. The Hippocratic oath read as follows:

I swear by Apollo, the physician, and Aesculapius and Hygeia and Panacea and all the gods and goddesses, that, according to my ability and judgment, I will keep this oath and this stipulation. . . . Whatever I see or hear in the life of men, whether in connection with my professional practice, or not, that ought not to be spoken of abroad, I will not divulge; considering that all such knowledge should be kept secret.

Quoted in Purrington, *An Abused Privilege*, 6 COLUM. L. REV. 388, 395-96 (1906).

The modern version of the oath reads as follows:

Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of man, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

Quoted in *Horne v. Patton*, 291 Ala. 701, 708, 287 So. 2d 824, 829 (1973).

203. Note, *supra* note 191, at 109. The argument could also be based upon a state's professional code. In California, for example, the Business and Professional Code provides that "willfully betraying a professional secret constitutes unprofessional conduct." CAL. BUS. & PROF. CODE § 2379 (West 1974). Section 2960(g), which is applicable to psychologists, provides that "willful, unauthorized communication of information received in professional confidence" makes the psychologist subject to disciplinary action. *Id.* § 2960(g). Indeed, the American Medical Association Code of Ethics states:

A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 9 (1957), quoted in Note, *supra* note 191, at 104 n.11.

204. The requirement of secrecy could also be considered an implied term in a contract between the addict and physician. See Note, *supra* note 191, at 104. This view would not ordinarily be applicable to treatment relationships, because usually there is no "employment contract." If, however, the treatment program is private with the client paying for services, an employment contract would exist and a term requiring secrecy could be implied. This would give the client a contract action were the physician to disclose the information. See *Clayman v. Bernstein*, 38 Pa. D.&C. 543 (Phila. County C.P. 1940). In *Clayman*, a physician took photographs of a patient showing facial disfigurement resulting from the patient's illness. The court dismissed preliminary objections to the bill in equity to enjoin the physician from developing or using the film, negatives, or prints of the photographs. See also DeWitt, *Medical Ethics and the Law: The Conflict between Dual Allegiances*, 5 W. RES. L. REV. 5, 20-23 (1953).

205. Indeed, the physician-patient relationship has been described as fiduciary. See, e.g., *Alexander v. Knight*, 25 Pa. D.&C.2d 649, 655 (Phila. County C.P. 1961), aff'd, 197 Pa. Super. 79, 177 A.2d 442 (1962). See also Boyle, *Medical Confidence —*

an action for breach of the physician's fiduciary duty. These arguments were subtly implied in *Felber*. The plaintiff claimed that the statute might require licensed physicians to violate professional standards of conduct.²⁰⁶ This contention was rejected because the "Hippocratic oath has been analyzed as no vow of absolute secrecy, but rather as imposing a general obligation on the physician to abstain from gossip."²⁰⁷ The *Felber* court said nothing more about the plaintiff's argument, completely ignoring the fact that the Hippocratic oath has also been interpreted as requiring secrecy.²⁰⁸

In contrast, the *Horne* court held that the confidential nature of the physician-patient relationship imposed a duty upon the physician not to disclose medical information.²⁰⁹ According to the court, imposition of this duty was required by the state public policy that "information obtained by a physician in the course of a doctor-patient relationship be maintained in confidence unless public interest or the private interest of the patient demand[ed] otherwise."²¹⁰ This public policy was derived from three sources: the state professional code;²¹¹ the Hippocratic oath;²¹² and the American Medical Association Principles of Medical Ethics.²¹³

Civil Liability for Breach, 24 No. IRE. L.Q. 19 (1973), wherein the author, in discussing British law, analyzes whether liability for disclosure could be based upon a breach of duty arising from the doctor's confidential relationship to his patient and concludes affirmatively. *Id.* at 38-39. Boyle decided that the three elements necessary to the imposition of such liability — that the information be of a confidential nature, that it be communicated in circumstances importing an obligation of confidence, and that there be an unauthorized use of the information — would all be present if a physician made an unauthorized disclosure of information regarding a patient. *Id.* at 26-28.

206. 331 F. Supp. at 87.

207. *Id.* at 87 n.5, citing Purrington, *An Abused Privilege*, 6 COLUM. L. REV. 388 (1906). Purrington interpreted the oath as follows:

Here is no vow of absolute secrecy; not even a limitation of duty to patients. It is a general obligation that the physician will abstain from gossip and observe a decent regard for the privacy of all men, not saying what in his judgment were better left unsaid.

6 COLUM. L. REV. at 395-96.

208. Note, *supra* note 191, at 109.

209. 291 Ala. at 708-09, 287 So. 2d at 829-30. The court also held that the physician breached the implied contract between physician and patient that the physician would keep all personal information confidential. *Id.* at 709-10, 711, 287 So. 2d at 830-31, 832.

210. *Id.* at 708, 287 So. 2d at 829.

211. 10 ALA. CODE tit. 46, § 257(21) (14) (Cum. Supp. 1973). This section provides: The state licensing board for the healing arts shall have the power and it is its duty to suspend for a specified time to be determined in the discretion of the board, or revoke any license to practice the healing arts of any branch thereof in the state of Alabama whenever the licensee shall be found guilty of any of the following acts or offenses; . . . (14) Wilful betrayal of a professional secret.

212. See note 201 *supra*.

The *Horne* court's analysis²¹⁴ would seem to provide an addict with a remedy of damages if his physician made an unauthorized disclosure of his condition to an employer. However, such a remedy would possibly not exist for disclosures mandated by reporting statutes or perhaps those made voluntary to law enforcement officials because of the public interest in disclosure.

E. Conversion

The final legal theory upon which an addict may arguably base a right to confidentiality is a conversion theory. At the root of this approach is the view that a person's identity and personal information can be considered his personal property. The individual would "own" this information. Because of this ownership, the individual would have the right to use the information as he wishes, either to disclose or refuse to disclose the information, or to grant permission to disclose or to withhold such permission. Consequently, use or disclosure of the information without the owner's authorization would be a conversion, giving the owner a tort remedy against a wrongdoer.²¹⁵ One author recognized the need for such a concept of property when he stated:

[P]ersonal information . . . should be defined as a property right, with all the restraints on interference by public or private authorities and due-process guarantees that our law of property has been so skillful in devising.²¹⁶

Under this view, not only would the addict have a conversion action if his property — his personal information — were interfered with, but also all the requirements of procedural and substantive due process would have to be met if there were any governmental interference with the right.²¹⁷ This approach is novel and currently has no support in case law. Nevertheless, if intangible property can be converted,²¹⁸ and if personal information can be considered property, the argument that unauthorized disclosure is a conversion would appear to be meritorious.

214. As the *Horne* court noted, several jurisdictions have reached the same result by basing the duty upon a testimonial privilege statute. 291 Ala. at 706, 287 So. 2d at 837. See, e.g., *Hammonds v. Aetna Cas. & Sur. Co.*, 237 F. Supp. 96 (N.D. Ohio 1965); *Felis v. Greenberg*, 51 Misc. 2d 441, 273 N.Y.S.2d 288 (Sup. Ct. 1966); *Clark v. Geraci*, 29 Misc. 2d 791, 208 N.Y.S.2d 564 (Sup. Ct. 1960); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958); *Smith v. Driscoll*, 94 Wash. 441, 162 P. 572 (1917).

215. See generally W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 79-97 (1971).

216. A. WESTIN, *PRIVACY AND FREEDOM* 324-25 (1967).

217. See generally Landynski, *Due Process and the Concept of Ordered Liberty: "A Screen of Words Expressing Will in the Service of Desire"?* 2 HOFSTRA L. REV. 1 (1974).

218. See Comment, *A New Found Holiday: the Conversion of Intangible Property*, 1972 UTAH L. REV. 511, wherein the author argues that there is no reason to preclude conversion actions for intangible property.

V. CONCLUSION

A serious drug abuse problem exists in this country. There has been a congressional determination that the problem is to be attacked at the level of the individual through medical methods. For a medical attack upon the problem to be successful, voluntary enrollment in treatment programs and active cooperation by addicts in mandatory treatment programs must be encouraged. Such encouragement cannot be effective if addicts believe that entrance into the program will merely create another source of information about them that can be used to their detriment by law enforcement officers, employers, or any other individual or group in society. Therefore, it is essential that addicts be guaranteed that their anonymity and the confidentiality of their medical records will be preserved. At present, the law does not allow such assurances. But the present laws need be extended only slightly to permit such assurances. Federal statutes, state statutes, evidentiary privileges, constitutional concepts of privacy, and common law notions of tort could be utilized to construct for the addict a legal network that would encourage him to seek medical help for his problem.

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